

Outreach & HDM 2005

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I. General Information

I.A. Assessment Information (Date, type, etc.)

1. What is the date of the assessment?

____/____/____

2. Specify the type of assessment.

- ☐ Initial assessment
☐ Reassessment

3. What is the date of the client's next assessment?

____/____/____

4. What is the name of the person conducting this assessment?

5. What is the name of the agency the assessor works for?

6. Who was the client referred by?

- ☐ Agency
☐ Family
☐ Friend
☐ Hospital
☐ Other
☐ Self
☐ Unavailable

7. Where was the client interviewed?

- ☐ Home
☐ Hospital
☐ Nursing facility
☐ Other

8. What is the Termination Date?

____/____/____

9. What are the reasons for Termination?

- ☐ Client Relocated
☐ Client Request
☐ Death
☐ Hospitalization
☐ Independence
☐ Nursing Home
☐ Other

I.B. Client Identification

1.a. What is the client's last name?

1.b. What is the client's first name?

1.c. What is the client's middle initial?

2. What is the client's Social Security Number?

3. What is the client's date of birth?

4. Enter the age of the client in years.

5. What is the client's gender?

- ☐ Male
☐ Female

6. Enter the client's telephone number.

7.a. Enter the client's mailing street address or Post Office box.

7.b. Enter the client's mailing city or town.

7.c. Enter the client's mailing state.

7.d. Enter the client's mailing ZIP code.

8.a. Enter the client's residential street address or Post Office box.

8.b. Enter the client's residential city or town.

9. Describe how to get to the client's home.

I.C. Contact Information

1.a. Name of Friend or Relative (other than Spouse/Partner) to con

1.b. Relationship of Friend or Relative (other than Spouse/Partner)

1.c. Work Telephone Number of Friend or Relative (other than Spo

1.d. Home Telephone Number of Friend or Relative (other than Spo

2.a. What is the name of the client's primary care physician?

2.b. What is the work phone number for the client's primary care p

3.a. What is the name of the client's guardian?

3.b. Enter the work phone number of the client's guardian.

3.c. Enter the home phone number of the client's guardian.

3.d. What Is the Mailing Address of the Guardian?

II. Demographics

II.A. Demographics and Indicators (Incl. ethnicity, poverty, etc.)

1. What is the client's ethnicity?

- ☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

1.a. Enter the client's self-described ethnic background.

2. What is the client's race?

- ☐ American Indian/Native Alaskan
☐ Asian
☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander
☐ Non-Minority (White, non-Hispanic)
☐ Other
☐ White-Hispanic

3. Specify the client's primary language.

- ☐ English
☐ French
☐ German
☐ Italian
☐ Spanish
☐ Other

4. Select the client's current marital status.

- ☐ Single
☐ Married
☐ Separated
☐ Widowed
☐ Divorced
☐ Unavailable

4.a. What is the name of the client's spouse/partner?

5. Indicate the type of residence that the client currently resides in

- ☐ House
☐ Private apartment
☐ Private apartment in senior housing
☐ Nursing home
☐ Unavailable

☐ Other

6. Does the client own or rent his/her residence?

- ☐ Own
☐ Rent
☐ Unknown

7. Select the client's current living arrangement.

- ☐ Lives Alone
☐ With spouse/partner
☐ Lives with spouse and child
☐ With child/children
☐ Other

8. Does the client reside in a rural area?

- ☐ No
☐ Yes

9. Is the client's income level below the national poverty level?

- ☐ No
☐ Yes

10. Is the client socially isolated?

- ☐ No
☐ Yes

III. Health Information

III.A. Nutrition

1. What is the client's idea of his/her appetite?

- ☐ Don't know
☐ Fair
☐ Good
☐ Poor

2. Is the client on any special diets for medical reasons?

- ☐ No
☐ Yes

3. Describe the client's special diet(s).

4. Does the client have trouble eating well due to other problems?

- ☐ No
☐ Yes

5. Describe the client's other problems that keep him/her from eating.

III.A-1. Nutrition Screening Checklist

1. Has the client made any changes in lifelong eating habits because of health problems?

- ☐ Don't know
☐ No
☐ Yes

2. Does the client eat fewer than 2 meals per day?

- ☐ No
☐ Yes

3. Does the client eat fewer than five (5) servings (1/2 cup each) of fruits and vegetables per day?

- ☐ No
☐ Yes

4. Does the client eat fewer than two servings of dairy products (such as milk, cheese, or yogurt) per day?

- ☐ No
☐ Yes

5. Does the client sometimes not have enough money to buy food?

- ☐ Don't know
☐ No
☐ Yes

6. Does the client have trouble eating well due to problems with chewing or swallowing?

- ☐ No
☐ Yes

7. Does the client eat alone most of the time?

- ☐ Don't know
☐ No
☐ Yes

8. Without wanting to, has the client lost or gained 10 pounds in the last 12 months?

- ☐ Don't know
☐ No
☐ Yes
☐ Yes, gained 10 pounds
☐ Yes, lost 10 pounds

9. Is the client not always physically able to shop, cook and/or feed himself/herself?

- ☐ Don't know
☐ No
☐ Yes

10. Does the client have 3 or more drinks of beer, liquor or wine alcohol per week?

- ☐ Don't know
☐ No
☐ Yes

11. Does the client take 3 or more different prescribed or over-the-counter medications?

- ☐ Don't know
☐ No
☐ Yes

III.B. Impairments

1. Does the client have problems with vision that are not corrected?

- ☐ No
☐ Yes

2. Does the client have problems with hearing that are not corrected?

- ☐ No
☐ Yes
☐ Yes, being treated
☐ Yes, not being treated

3. Does the client have problems with speech that are not corrected?

- ☐ No
☐ Yes

4. Does the client use a cane?

- ☐ No
☐ Yes

5. Does the client use a walker to get around?

- ☐ No
☐ Yes

6. Does the client use a wheelchair to get around?

- ☐ No
☐ Yes

III.C. Current Health Status

1. What is the client's height?

2. What is the client's weight?

3. Indicate which of the following conditions/diagnoses the client c

- ☐ Alzheimer's disease/cognitive impairment/dementia
☐ Ankle/leg swelling
☐ Arthritis
☐ Breathing disorders
☐ Cancer
☐ Cataract
☐ Diabetes
☐ Hearing impairment
☐ Heart problems
☐ Hypertension
☐ Mental/emotional condition
☐ Stroke/neurological problems
☐ Traumatic brain injury
☐ Urinary problems
☐ Vision problems
☐ Other
☐ None of the Above

III.D. Medication Use

1. List the names of all over the counter (OTC) medications and cli

2. How many prescription medications does the client take?

3. List the names of all prescription medications and client's stated

III.E. Cognitive/Emotional Status

1. Select the choice that most accurately describes the client's mer

- ☐ Cannot remember
☐ Minimal difficulty remembering
☐ More difficulty remembering
☐ No difficulty remembering

2. Comments regarding Dementia (memory/cognition issues)

3. Has the client felt depressed, sad, or unhappy?

- ☐ No
☐ Yes
☐ Sometimes

IV. Services/Program Information

IV.A. Current Participation in Services/Program

Is the client participating in any of the following services or program

- ☐ 1 - Adult Day Care
- ☐ 2 - Adult Family Foster Care
- ☐ 3 - Assisted Living
- ☐ 4 - Assistive Devices
- ☐ 5 - Basic Care
- ☐ 6 - Caregiver Support
- ☐ 7 - Case Management
- ☐ 8 - Chore
- ☐ 9 - Congregate meals
- ☐ 10 - Developmental Disability Services
- ☐ 11 - Emergency (telephone) Lifeline
- ☐ 12 - Escort/Non-Medical Transportation
- ☐ 13 - Family Home Care
- ☐ 14 - Food Stamps
- ☐ 15 - Fuel Assistance
- ☐ 16 - Health Maintenance
- ☐ 17 - Home Delivered Meals
- ☐ 18 - Home Health Care
- ☐ 19 - Homemaker Services
- ☐ 20 - Housing Assistance
- ☐ 21 - Job Counseling/Vocational Rehabilitation
- ☐ 22 - Legal Services
- ☐ 23 - Medicaid
- ☐ 24 - Mental Health/Substance Abuse Services
- ☐ 25 - Nursing Facility
- ☐ 26 - Nutrition Counseling
- ☐ 27 - Outreach Program
- ☐ 28 - Personal Care
- ☐ 29 - Prescription Assistance
- ☐ 30 - QMB/SLMB
- ☐ 31 - Respite Care
- ☐ 32 - Senior Companion
- ☐ 33 - Social Security
- ☐ 34 - SSI
- ☐ 35 - Telephone Reassurance - Friendly Visitor
- ☐ 36 - Transportation
- ☐ 37 - Veteran's Benefits
- ☐ 38 - Vision Services
- ☐ 39 - Weatherization
- ☐ 40 - Other

- ☐ 3 - Assisted Living
- ☐ 4 - Assistive Devices
- ☐ 5 - Basic Care
- ☐ 6 - Caregiver Support
- ☐ 7 - Case management
- ☐ 8 - Chore
- ☐ 9 - Congregate Meals
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- ☐ 36 - Transportation
- ☐ 37 - Veteran's Benefits
- ☐ 38 - Vision Services
- ☐ 39 - Weatherization
- ☐ 40 - Other

IV.B. Consider Applying for the Following Services/Program

Does the client want to apply for any of the following services or p

- ☐ 1 - Adult Day Care
- ☐ 2 - Adult Family Foster Care

V. ADL's/IADL's**V.A. Activities of Daily Living (ADL)**

1. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

2. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totality dependence

3. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

4. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

5. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

6. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally Dependent

V.B. Instrumental Activities of Daily Living (IADL)

1. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

2. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires Assistance
☐ 3 - Totally dependent

3. Specify the client's ability to **MANAGE MONEY**.

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

4. Specify the client's ability to perform **HEAVY HOUSEWORK**.

- ☐ 1 - Independent

- ☐ 2 - Requires assistance
☐ 3 - Totally dependent

5. Specify the client's ability to perform **LIGHT HOUSEKEEPING**.

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

6. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

7. During the past 7 days, and considering all episodes, how would

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent

8. Rank the client's ability to use the **TELEPHONE**.

- ☐ 1 - Independent
☐ 2 - Requires assistance
☐ 3 - Totally dependent